FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041590

Facility Name: INTERNATIONAL VILLAGE

Address: 4815 SOUTH WESTERN AVENUE (Number) CHICAGO (City) 60609 (Zip Code)

County: COOK

Telephone Number: (773) 927-4200 **Fax #** (773) 927-8742

IDPA ID Number: 363928303001

Date of Initial License for Current Owners: 09/11/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	218	TOTALS	218	79,570	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,056	178	4,152	8,386	8
9	SNF/PED					9
10	ICF	21,391	1,442	71	22,904	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,447	1,620	4,223	31,290	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.32%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/11/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/11/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 4131

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	146,135	13,688	24,379	184,202		184,202	(6,781)	177,421			1
2	Food Purchase		109,080		109,080		109,080	1,511	110,591			2
3	Housekeeping	84,786	17,610		102,396		102,396	973	103,369			3
4	Laundry	21,591	9,300		30,891		30,891		30,891			4
5	Heat and Other Utilities			239,747	239,747		239,747	1,289	241,036			5
6	Maintenance	60,231		199,166	259,397		259,397	6,577	265,974			6
7	Other (specify):*							1,101	1,101			7
8	**TOTAL General Services**	312,743	149,678	463,292	925,713		925,713	4,670	930,383			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,039,538	32,214	66,895	1,138,647		1,138,647	7,086	1,145,733			10
10a	Therapy	51,822	7,898	11,054	70,774		70,774	(662)	70,112			10a
11	Activities	62,135	4,538	8,596	75,269		75,269	(2,672)	72,597			11
12	Social Services	52,537		17,155	69,692		69,692	(16,097)	53,595			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							8,744	8,744			15
16	**TOTAL Health Care and Programs**	1,206,032	44,650	112,700	1,363,382		1,363,382	(3,602)	1,359,780			16
	C. General Administration											
17	Administrative	10,953		60,033	70,986		70,986	31,388	102,374			17
18	Directors Fees											18
19	Professional Services			354,235	354,235	(162)	354,073	(299,012)	55,061			19
20	Dues, Fees, Subscriptions & Promotions			93,761	93,761		93,761	(71,229)	22,532			20
21	Clerical & General Office Expenses	144,881	16,321	122,564	283,766		283,766	(27,062)	256,704			21
22	Employee Benefits & Payroll Taxes			286,133	286,133		286,133	(28,503)	257,630			22
23	Inservice Training & Education			191	191		191		191			23
24	Travel and Seminar			5,975	5,975		5,975	681	6,656			24
25	Other Admin. Staff Transportation			129	129		129	126	255			25
26	Insurance-Prop.Liab.Malpractice			161,995	161,995		161,995	(12,701)	149,294			26
27	Other (specify):*							18,697	18,697			27
28	**TOTAL General Administration**	155,834	16,321	1,085,016	1,257,171	(162)	1,257,009	(387,614)	869,395			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,674,609	210,649	1,661,008	3,546,266	(162)	3,546,104	(386,546)	3,159,558			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number INTERNATIONAL VILLAGE #0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			90,606	90,606		90,606	387,690	478,296			30
31	Amortization of Pre-Op. & Org.							108,573	108,573			31
32	Interest			233,235	233,235		233,235	742,534	975,769			32
33	Real Estate Taxes			120,000	120,000	162	120,162	1,870	122,032			33
34	Rent-Facility & Grounds			926,991	926,991		926,991	(924,424)	2,567			34
35	Rent-Equipment & Vehicles			2,283	2,283		2,283	1,938	4,221			35
36	Other (specify):*							3,159	3,159			36
37	**TOTAL Ownership**			1,373,115	1,373,115	162	1,373,277	321,340	1,694,617			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		190,518	122,054	312,572		312,572	(5,118)	307,454			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,355	119,355		119,355		119,355			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		190,518	241,409	431,927		431,927	(5,118)	426,809			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,674,609	401,167	3,275,532	5,351,308		5,351,308	(70,324)	5,280,984			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(195,237)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,327)	21		24
25	Fund Raising, Advertising and Promotional	(55,704)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	38,470			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (274,854)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	204,530		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 204,530		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (70,324)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

INTERNATIONAL VILLAGE

ID# 0041590

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft Loss	$ (2,915)	21	1
2	Prior Period Adjustment - Union Dues	(1,614)	22	2
3	Prior Period Adjustment - Interest	(49,878)	32	3
4	Prior Period Adjustment - Insurance	(13,361)	26	4
5	Prior Year Legal Fees	(1,713)	19	5
6	Amortization of Pre-operating Costs	108,573	31	6
7	ICTC - COPE	(622)	20	7
8				8
9				9
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			2,488	(7,957)		(1,312)						(6,781)	1
2	Food Purchase	(56)		(234)			1,801						1,511	2
3	Housekeeping			973									973	3
4	Laundry													4
5	Heat and Other Utilities			1,289									1,289	5
6	Maintenance			7,142	(565)								6,577	6
7	Other (specify):*			1,008			93						1,101	7
8	**TOTAL General Services**	(56)		12,666	(8,522)		582						4,670	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			14,575	(56,327)	50,763	17	(1,942)					7,086	10
10a	Therapy			2,906	(3,568)								(662)	10a
11	Activities			1,125	(3,797)								(2,672)	11
12	Social Services			1,058	(17,155)								(16,097)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			2,500		6,244							8,744	15
16	**TOTAL Health Care and Programs**			22,164	(80,848)	57,007	17	(1,942)					(3,602)	16
	C. General Administration													
17	Administrative			23,441	(60,033)	67,936	44						31,388	17
18	Directors Fees													18
19	Professional Services	(1,713)		3,436	(300,743)		8						(299,012)	19
20	Fees, Subscriptions & Promotions	(56,326)	4,050	936	(19,893)		4						(71,229)	20
21	Clerical & General Office Expenses	(65,242)	788	67,228	(29,913)		77						(27,062)	21
22	Employee Benefits & Payroll Taxes	(1,614)			(26,889)								(28,503)	22
23	Inservice Training & Education													23
24	Travel and Seminar			681									681	24
25	Other Admin. Staff Transportation			37			89						126	25
26	Insurance-Prop.Liab.Malpractice	(13,361)		660									(12,701)	26
27	Other (specify):*			10,191		8,506							18,697	27
28	**TOTAL General Administration**	(138,256)	4,838	106,610	(437,470)	76,442	222						(387,614)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(138,312)	4,838	141,440	(526,840)	133,449	821	(1,942)					(386,546)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(195,237)	577,880	5,047									387,690	30
31	Amortization of Pre-Op. & Org.	108,573											108,573	31
32	Interest	(49,878)	787,129	5,282			1						742,534	32
33	Real Estate Taxes			1,870									1,870	33
34	Rent-Facility & Grounds		(926,991)	2,567									(924,424)	34
35	Rent-Equipment & Vehicles			1,933			5						1,938	35
36	Other (specify):*		3,159										3,159	36
37	**TOTAL Ownership**	(136,542)	441,177	16,699			6						321,340	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,699)	(3,419)					(5,118)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(1,699)	(3,419)					(5,118)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(274,854)	446,015	158,139	(526,840)	133,449	(873)	(5,361)					(70,324)	45

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				HIGHLANDER CARE CENTER, LLC		BLDG. CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 926,991	HIGHLANDER CARE CENTER, LLC		$	$ (926,991)	1
2	V	36	Amortization				3,159	3,159	2
3	V	21	Annual Report Fee				788	788	3
4	V	30	Depreciation				577,880	577,880	4
5	V	20	Hiring Costs				4,050	4,050	5
6	V	32	Interest Expense				787,129	787,129	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 926,991			$ 1,373,006	$ * 446,015	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 2,488	$ 2,488	15
16	V	2	FOOD				(234)	(234)	16
17	V	3	HOUSEKEEPING				973	973	17
18	V	5	UTILITIES				1,289	1,289	18
19	V	6	REPAIRS AND MAINT.				7,142	7,142	19
20	V	7	EMP. BEN. - GEN. SERV.				1,008	1,008	20
21	V	10	NURSING				14,575	14,575	21
22	V	10A	THERAPY				2,906	2,906	22
23	V	11	ACTIVITIES				1,125	1,125	23
24	V	12	SOCIAL SERVICES				1,058	1,058	24
25	V	15	EMP. BEN. - HEALTHCARE				2,500	2,500	25
26	V	17	ADMINISTRATIVE				23,441	23,441	26
27	V	19	PROFESSIONAL FEES				3,436	3,436	27
28	V	20	DUES, SUBSCRIPTIONS				936	936	28
29	V	21	CLERICAL AND GENERAL				67,228	67,228	29
30	V	24	SEMINARS				681	681	30
31	V	25	AUTO EXPENSE				37	37	31
32	V	26	INSURANCE				660	660	32
33	V	27	EMP. BEN. - GEN. ADMIN.				10,191	10,191	33
34	V	30	DEPRECIATION				5,047	5,047	34
35	V	32	INTEREST				5,282	5,282	35
36	V	33	REAL ESTATE TAXES				1,870	1,870	36
37	V	34	BUILDING RENT - UNRELATED				2,567	2,567	37
38	V	35	EQUIPMENT RENTAL				1,933	1,933	38
39	Total			$			$ 158,139	$ * 158,139	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 7,957	CARE CENTERS, INC.	100.00%	$	$ (7,957)	15
16	V	19	ACCOUNTING	15,000	CARE CENTERS, INC.			(15,000)	16
17	V	19	ANCIL ADMIN FEE	26,160	CARE CENTERS, INC.			(26,160)	17
18	V	19	BOOKEEPING	44,472	CARE CENTERS, INC.			(44,472)	18
19	V	19	DATA PROCESSING	7,848	CARE CENTERS, INC.			(7,848)	19
20	V	19	LEGAL	19,893	CARE CENTERS, INC.			(19,893)	20
21	V	19	MANAGEMENT FEE	183,120	CARE CENTERS, INC.			(183,120)	21
22	V	19	PROFESSIONAL FEES	4,250	CARE CENTERS, INC.			(4,250)	22
23	V	20	ADVERTISING	19,893	CARE CENTERS, INC.			(19,893)	23
24	V	25	REBILL BUS		CARE CENTERS, INC.				24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	26,889	CARE CENTERS, INC.			(26,889)	26
27	V	1	REBILL. PAYROLL DIETARY		CARE CENTERS, INC.				27
28	V	3	REBILL. PAYROLL HSKPNG		CARE CENTERS, INC.				28
29	V	6	REBILL. PAYROLL MAINT.	565	CARE CENTERS, INC.			(565)	29
30	V	10	REBILL. PAYROLL NURSING	56,327	CARE CENTERS, INC.			(56,327)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	3,568	CARE CENTERS, INC.			(3,568)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	3,797	CARE CENTERS, INC.			(3,797)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	17,155	CARE CENTERS, INC.			(17,155)	33
34	V	17	REBILL. PAYROLL ADMIN.	60,033	CARE CENTERS, INC.			(60,033)	34
35	V	21	REBILL. PAYROLL CLERICAL	29,913	CARE CENTERS, INC.			(29,913)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 526,840			$	$ * (526,840)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 50,763	$ 50,763	15
16	V	15	EMP. BEN HEALTHCARE				6,244	6,244	16
17	V	17	ADMINISTRATIVE				67,936	67,936	17
18	V	27	EMP. BEN GEN. ADMIN.				8,506	8,506	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 133,449	$ * 133,449	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 1,018	$ 1,018	15
16	V	2	FOOD				1,801	1,801	16
17	V	6	MAINTENANCE						17
18	V	7	EMP. BEN. - GEN. SERV.				93	93	18
19	V	10	NURSING				17	17	19
20	V	17	ADMINISTRATIVE				44	44	20
21	V	19	PROFESSIONAL FEES				8	8	21
22	V	20	DUES, FEES, SUB.				4	4	22
23	V	21	CLERICAL & GENERAL				77	77	23
24	V	24	SEMINARS						24
25	V	25	TRAVEL				89	89	25
26	V	32	INTEREST				1	1	26
27	V	35	RENT - EQUIPMENT & VEHICLES				5	5	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				59	59	28
29	V	1	DIETARY SUPP	2,330				(2,330)	29
30	V	39	ANCILLARY SUPP	1,758				(1,758)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,089			$ 3,216	$ * (873)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 15,992	$ 15,992	15
16	V	39	MEDICAL SUPPLIES				28,150	28,150	16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	17,934				(17,934)	19
20	V	39	MEDICAL SUPPLIES	31,569				(31,569)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 49,503			$ 44,142	$ * (5,361)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 27,288	$ 27,288	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	27,288				(27,288)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,288			$ 27,288	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0	see attached	1.01	1.40%		$		1
2	Mark Steinberg	Relative	Administrative	0	see attached	1.03	2.06%	CCI salary	913	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 913		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	31,290	$ 2,488	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		31,290	(234)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	31,290	973	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		31,290	1,289	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	31,290	7,142	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		31,290	1,008	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	31,290	14,575	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	31,290	2,906	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	31,290	1,125	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	31,290	1,058	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		31,290	2,500	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	31,290	23,441	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		31,290	3,436	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		31,290	936	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	31,290	67,228	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		31,290	681	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		31,290	37	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		31,290	660	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		31,290	10,191	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		31,290	5,047	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		31,290	5,282	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		31,290	1,870	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		31,290	2,567	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		31,290	1,933	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 158,139	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296		50,763	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011			6,244	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		67,936	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			8,506	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 133,449	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	4,089	1,018	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		4,089	1,801	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		4,089		3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		4,089	93	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		4,089	17	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		4,089	44	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		4,089	8	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		4,089	4	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		4,089	77	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		4,089		10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		4,089	89	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		4,089	1	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		4,089	5	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		4,089	59	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 3,216	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 15,992	1
2	39	MEDICAL SUPPLIES	DIRECT ALLOCATION						28,150	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 44,142	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 27,288	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 27,288	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Corrus Bank		X	Construction Loan			$	$ 9,349,463			$ 787,129	1
2	Corrus Bank		X	Second Mortgage				1,000,000				2
3												3
4												4
5												5
	Working Capital											
6	A1 Corporation		X	Insurance Financing							632	6
7	Care Center, Inc.	X		Working Capital							150,592	7
8	Shareholders Loans	X		Working Capital				600,000			47,448	8
9	TOTAL Facility Related						$	$ 10,949,463			$ 985,801	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Allocation from Care Centers										5,283	11
12	Reduction for prior year overstatement										(15,315)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,032)	14
15	TOTALS (line 9+line14)						$	$ 10,949,463			$ 975,769	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	240,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	7,735	2
3. Under or (over) accrual (line 2 minus line 1).	$	(232,265)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	354,135	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	162	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	122,032	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000	5,865	12

2001 Accrual = FY2000 overaccrual + estimated FY2001 RE Tax

Allocation from Care Centers Inc. $1870

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME INTERNATIONAL VILLAGE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0041590

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-07-104-001-0000	Long Term Care Property	$	$
2.	20-07-104-003-0000	Long Term Care Property	$	$
3.	20-07-104-004-0000	Long Term Care Property	$	$
4.	20-07-104-005-0000	Long Term Care Property	$	$
5.	20-07-104-009-0000	Long Term Care Property	$	$
6.	20-07-104-011-0000	Long Term Care Property	$	$
7.	20-07-104-012-0000	Long Term Care Property	$	$
8.	See attached	Home office allocation	$ 66,987.00	$ 1,377.00
9.			$	$
10.	SEE ATTACHED NOTE		$	$
		TOTALS	$ 66,987.00	$ 1,377.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,132 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 542,867
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 108,573
4. Dates Incurred: Prior to 9/11/00

Nature of Costs: various pre-operating expenses
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	115,710	1995	$ 901,533	1
2	Allocation from Care Centers			1,315	2
3	TOTALS	115,710		$ 902,848	3

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	218			2000	$ 12,627,413	$ 323,780	35	$ 360,783	$ 37,003	$ 450,979	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		29,371	776		987	211	4,861	68
69	Financial Statement Depreciation			5,343			(5,343)		69
70	TOTAL (lines 4 thru 69)		$ 12,656,784	$ 329,899		$ 361,770	$ 31,871	$ 455,840	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,656,784	$ 329,899		$ 361,770	$ 31,871	$ 455,840	1
2	TELEPHONE WIRING	2000	1,884			94	94	118	2
3	INSTALL OF SATELLITE	2000	2,920			146	146	183	3
4	218 OUTLETS	2000	18,495			925	925	1,079	4
5	ELECTRICAL WIRING	2000	6,161			308	308	359	5
6	ELECTRICAL WIRING	2000	296			15	15	18	6
7	ELECTRICAL WIRING	2000	468			23	23	27	7
8	ELECTRICAL WIRING	2000	327			16	16	19	8
9	ELECTRICAL WIRING	2000	197			10	10	12	9
10	OUTLETS FOR TV UNITS	2000	1,508			75	75	88	10
11	LANDSCAPING	2000	3,861			193	193	257	11
12	LANDSCAPING	2000	1,155			58	58	77	12
13	VOICE ALARM	2000	337			17	17	23	13
14	VOICE ALARM	2000	903			45	45	60	14
15	VOICE ALARM	2000	24,785			1,239	1,239	1,652	15
16	SIGNS	2000	127			6	6	8	16
17	SIGNS	2000	2,439			122	122	163	17
18	SHOWER CURTAINS	2000	1,065			53	53	71	18
19	LIGHTING SUPPLIES	2000	923			46	46	61	19
20	LIGHTING SUPPLIES	2000	178			9	9	12	20
21	LIGHTING SUPPLIES	2000	879			44	44	59	21
22	LIGHTING SUPPLIES	2000	258			13	13	17	22
23	LIGHTING SUPPLIES	2000	127			6	6	8	23
24	LIGHTING SUPPLIES	2000	144			7	7	9	24
25	REMOVING DEBRIS	2000	7,000			350	350	467	25
26	AVIARY	2000	14,628			731	731	975	26
27	ALARM SEC SERVICES	2000	16,517			826	826	1,101	27
28	OUTSIDE SIGNS	2000	4,710			236	236	315	28
29	OUTSIDE SIGNS	2000	1,445			72	72	96	29
30	LAWN SPRINKLER SYSTM	2000	17,000			850	850	1,133	30
31	ALARM SYSTEM INSTALL	2000	17,000			850	850	1,133	31
32	SIGNS	2000	4,000			200	200	267	32
33	SIGNS	2000	360			18	18	24	33
34	TOTAL (lines 1 thru 33)		$ 12,808,881	$ 329,899		$ 369,373	$ 39,474	$ 465,731	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,808,881	$ 329,899		$ 369,373	$ 39,474	$ 465,731	1
2	DECORATING	2000	1,871			94	94	125	2
3	SPRINKLER	2000	3,000			150	150	200	3
4	HAGEMASTER DEBRIS	2000	4,880			244	244	325	4
5	TELEPHONE WIRING	2000	642			32	32	43	5
6	SIGNS	2000	(4,710)			(236)	(236)	(315)	6
7	SIGNS	2000	5,260			263	263	351	7
8	TELEPHONE WIRING	2000	4,542			227	227	303	8
9	ELECTRICAL WIRING	2000	375			19	19	21	9
10	ELECTRICAL WIRING	2000	421			21	21	23	10
11	ELECTRICAL WIRING	2000	656			33	33	36	11
12	STORAGE SYSTEMS	2001	7,961			398	398	398	12
13	TELEPHONE WIRING	2001	562			28	28	28	13
14	CCTV	2001	1,196			60	60	60	14
15	CCTV	2001	641			32	32	32	15
16	DRAPERY	2001	2,324			106	106	106	16
17	CUBICLE CURTAINS	2001	1,632			75	75	75	17
18	TELEPHONE WIRING	2001	419			18	18	18	18
19	TELEPHONE WIRING	2001	555			23	23	23	19
20	TELEPHONE WIRING	2001	419			18	18	18	20
21	SURGE SUPPRESSOR	2001	860			36	36	36	21
22	TELEPHONE WIRING	2001	592			23	23	23	22
23	TELEPHONE WIRING	2001	681			26	26	26	23
24	TELEPHONE WIRING	2001	617			23	23	23	24
25	TELEPHONE WIRING	2001	690			29	29	29	25
26	TELEPHONE WIRING	2001	296			10	10	10	26
27	TELEPHONE WIRING	2001	691			23	23	23	27
28	TELEPHONE WIRING	2001	617			21	21	21	28
29	SATELLITE	2001	1,454			49	49	49	29
30	TELEPHONE WIRING	2001	839			25	25	25	30
31	TELEPHONE WIRING	2001	518			15	15	15	31
32	TELEPHONE WIRING	2001	395			12	12	12	32
33	TELEPHONE WIRING	2001	321			9	9	9	33
34	TOTAL (lines 1 thru 33)		$ 12,850,098	$ 329,899		$ 371,279	$ 41,380	$ 467,902	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,850,098	$ 329,899		$ 371,279	$ 41,380	$ 467,902	1
2	TELEPHONE WIRING	2001	358			11	11	11	2
3	IRON FENCE	2001	3,800			95	95	95	3
4	TELEPHONE WIRING	2001	1,911			48	48	48	4
5	TELEPHONE WIRING	2001	1,036			22	22	22	5
6	PLUMBING	2001	5,169			86	86	86	6
7	SPRINKLER SYSTEM REP	2001	518			9	9	9	7
8	HVAC	2001	625			10	10	10	8
9	TELEPHONE WIRING	2001	913			12	12	12	9
10	ANTI-FREEZE SPRINKLE	2001	1,320			17	17	17	10
11	CLEARING LOT	2001	4,847			61	61	61	11
12	TELEPHONE WIRING	2001	863			11	11	11	12
13	LANDSCAPING	2001	3,452			101	101	101	13
14	CODE ALERT	2001	693			9	9	9	14
15	HVAC	2001	875			11	11	11	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,876,478	$ 329,899		$ 371,782	$ 41,883	$ 468,405	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CCI alloc		1996	1996	$ 23,279	$ 597	35	$ 665	$ 68	$ 3,381	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Care Centers, Inc.			2001	66	9	20	2	(7)	2	9
10	Allocation from Care Centers, Inc.			2000	28	1	20	1		3	10
11	Allocation from Care Centers, Inc.			1999	417	11	20	21	10	60	11
12	Allocation from Care Centers, Inc.			1998	172	4	20	9	(5)	32	12
13	Allocation from Care Centers, Inc.			1997	2,442	43	20	135	92	787	13
14	Allocation from Care Centers, Inc.			1996	2,684	35	20	142	107	556	14
15	Allocation from Care Centers, Inc.			1997	283	66	20	12	(54)	40	15
16	Allocation from Care Centers, Inc.			1994	-	8	20		(8)		16
17	Allocation from Care Centers, Inc.			1993	-	2	20		(2)		17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 29,371	$ 776		$ 987	$ 201	$ 4,861	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,029,508	$ 336,562	$ 103,051	$ (233,511)		$ 139,094	71
72	Current Year Purchases	25,061	5,350	1,737	(3,613)		1,737	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,054,569	$ 341,912	$ 104,788	$ (237,124)		$ 140,831	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers allocation		$ 11,257	$ 1,722	$ 1,726	$ 4		$ 5,554	76
77										77
78										78
79										79
80	TOTALS			$ 11,257	$ 1,722	$ 1,726	$ 4		$ 5,554	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,845,152	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 673,533	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 478,296	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (195,237)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 614,790	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Loan Fees - 2000	$ 110,665	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 110,665	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers Inc.				2,567			5
6								6
7	TOTAL				$ 2,567 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,221 Description: Copier $1968, Water Cooler $315, allocation from Care Centers Inc. $1938
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 56,447	$		$ 56,447	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,835			6,835	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			58,772			58,772	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				123,205		123,205	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						67,313		67,313	13
14	TOTAL			$		$ 122,054	$ 190,518		$ 312,572	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 167,545	$ 167,545	1
2	Cash-Patient Deposits	12,670	12,670	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,413,715	1,413,715	3
4	Supply Inventory (priced at)		9,065	4
5	Short-Term Investments			5
6	Prepaid Insurance	82,810	82,810	6
7	Other Prepaid Expenses	5,746	5,746	7
8	Accounts Receivable (owners or related parties)	1,273,148	1,273,148	8
9	Other(specify): See supplemental schedule	904,012	936,712	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,859,646	$ 3,901,411	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		901,533	13
14	Buildings, at Historical Cost		13,426,070	14
15	Leasehold Improvements, at Historical Cost	218,126	218,126	15
16	Equipment, at Historical Cost	240,336	366,276	16
17	Accumulated Depreciation (book methods)	(106,043)	(941,384)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 352,419	$ 13,970,621	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,212,065	$ 17,872,032	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 262,199	$ 376,606	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,579	8,579	28
29	Short-Term Notes Payable		180,000	29
30	Accrued Salaries Payable	3,192,611	3,192,611	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,367	18,367	31
32	Accrued Real Estate Taxes(Sch.IX-B)	354,135	354,135	32
33	Accrued Interest Payable	82,011	82,011	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,158,738	5,009,959	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,076,640	$ 9,222,268	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	600,000	10,769,463	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 600,000	$ 10,769,463	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,676,640	$ 19,991,731	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,464,575)	$ (2,119,699)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,212,065	$ 17,872,032	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (92,947)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (92,947)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,371,628)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,371,628)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,464,575)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,940,554	1
2	Discounts and Allowances for all Levels	(856,958)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,083,596	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	681,407	6
7	Oxygen	1,590	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 682,997	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	120,783	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,570	19
20	Radiology and X-Ray	8,985	20
21	Other Medical Services	69,749	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 213,087	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,979,680	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	925,713	31
32	Health Care	1,363,382	32
33	General Administration	1,257,171	33
	B. Capital Expense		
34	Ownership	1,373,115	34
	C. Ancillary Expense		
35	Special Cost Centers	312,572	35
36	Provider Participation Fee	119,355	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,351,308	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,371,628)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,371,628)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,854	2,033	44,362	21.82	2
3	Registered Nurses	3,305	3,548	70,924	19.99	3
4	Licensed Practical Nurses	24,070	25,263	498,065	19.72	4
5	Nurse Aides & Orderlies	43,393	47,476	412,079	8.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,701	3,911	51,822	13.25	8
9	Activity Director	1,579	1,699	20,685	12.17	9
10	Activity Assistants	5,919	6,120	41,450	6.77	10
11	Social Service Workers	3,550	3,926	52,537	13.38	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,207	31,578	14.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,227	15,001	114,557	7.64	15
16	Dishwashers					16
17	Maintenance Workers	3,974	4,520	60,231	13.33	17
18	Housekeepers	11,458	12,039	84,786	7.04	18
19	Laundry	3,039	3,147	21,591	6.86	19
20	Administrator					20
21	Assistant Administrator	477	501	10,953	21.86	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,551	12,476	144,881	11.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,637	1,719	14,108	8.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,710	145,586	$ 1,674,609 *	$ 11.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	214	$ 8,520	01-03	35
36	Medical Director	monthly	9,000	09-03	36
37	Medical Records Consultant	monthly	1,361	10-03	37
38	Nurse Consultant	59	4,170	10-03	38
39	Pharmacist Consultant	monthly	5,037	10-03	39
40	Physical Therapy Consultant	95	4,673	10a-03	40
41	Occupational Therapy Consultant	54	2,700	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	113	10a-03	43
44	Activity Consultant	100	4,799	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	CCI payroll (see attached)		96,706	various	48
49	TOTAL (lines 35 - 48)	524	$ 137,079		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Koskius	Asst. Administrator	0	$ 10,953
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 10,953

B. Administrative - Other

Description	Amount
Administrator salary paid by CCI (adjusted out on page 6B)	$ 60,033
TOTAL (agree to Schedule V, line 17, col. 3)	$ 60,033
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 10,851
Deutsch, Levy & Engel	Legal - RE Estate Tax	162
Frost Ruttenberg & Rothblatt	Accounting	35,045
Crowe Chizek	Accounting	502
Maxxsource	Computer Services	2,245
Alpha Data	Data Processing	2,944
Jacobs Health Care	Computer Services	960
Personnel Planners	Unemployment Consult	784
Care Centers, Inc.	various - see attached	300,742
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 354,235

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,847
Unemployment Compensation Insurance	37,251
FICA Taxes	128,108
Employee Health Insurance	34,059
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Employee Tax	3,252
Pension Expense	5,884
Employee Physicals	1,545
Misc. Employee Welfare	4,558
Employee Drug Testing	1,126
TOTAL (agree to Schedule V, line 22, col.8)	$ 257,630

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	7,014
Health Care Worker Background Check	225
(Indicate # of checks performed 15)	
Advertising & Promotion	55,704
Dues & Subscriptions	914
Licenses & Fees	9,189
Allocation from Care Centers Inc.	940
Hiring Costs - Building Co.	4,050
Less: Public Relations Expense	
Non-allowable advertising	(55,704)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,532

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,975
Allocation from Care Centers Inc.	681
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,656

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $1367**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,581** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **119,355**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees